

Hyposkillia

Deficiency of Clinical Skills

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The medical profession today faces many problems. We march to bureaucratic drummers, we have lost our autonomy, our prestige has spiraled downward, and our professionalism is sagging.^{1,2} But our woes don't end there.

Lurking in the shadow of these ills is yet another medical malady, one for which we are solely responsible, and one that endangers the public we serve. It begins in medical school, where it almost never receives the attention it deserves. During residency training, it remains easy to spot, but efforts to spot it are not routine. And even when it becomes conspicuous, measures to correct it are often ignored, inadequate, or temporary at best.

I call this malady *hyposkillia*—deficiency of clinical skills. By definition, those afflicted are ill-equipped to render good patient care. Yet, residency training programs across the country are graduating a growing number of these “hyposkilliacs”—physicians who cannot take an adequate medical history, cannot perform a reliable physical examination, cannot critically assess the information they gather, cannot create a sound management plan, have little reasoning power, and communicate poorly. Moreover, they rarely spend enough time to know their patients “through and through.”³ And because they are quick to treat everybody, they learn nothing about the natural history of disease.

These individuals, however, do become proficient at a number of things. They learn to order all kinds of tests and procedures—but don't always know *when* to order or *how* to interpret them. They also learn to play the numbers game⁴—treating a number or some other type of test result rather than the patient to whom the number or test result pertains. And by using so many sophisticated tests and procedures, they inevitably and unwittingly acquire a laboratory-oriented rather than a patient-oriented mindset. Contributing to this mindset, incidentally, are the health maintenance organizations that force physicians to care for a maximum *number* of patients, in a minimal *number* of minutes, for the lowest *number* of dollars.

The problem of deficient clinical skills is long-standing and widespread.⁵⁻¹⁶ Its cause, however, is obvious—faulty training. And the fault, of course, lies with us, the teaching faculty. Why, then, do we allow such deficiencies to develop, persist, and grow? The answer, I believe, is two-fold.

First, society's overall values and priorities are not what they used to be. For example, when I trained in the mid-1950s, hard work, self pride, devotion to duty, strict accountability, and pursuit of excellence were the norms. Today, however, the emphasis is on limited work hours, on quests for personal gains, and on political correctness. Pride and (especially) accountability have mostly disappeared. As a result, people at all levels—including many medical students, house officers, and faculty members—are satisfied with mediocrity, the only norm they know.

The second part of my answer pertains to the training that the teachers, themselves, received. Most of today's medical teachers were trained after the early 1970s—the time when modern medical technology began to burgeon. High-*tech* medicine is all they've ever seen, all they know, and, therefore, all they can teach. Through no fault of their own, they have no real sense of high-touch medicine.

What do I mean by high-*touch* medicine? I mean medicine based on a carefully constructed medical history coupled with a pertinent physical examination and critical assessment of the information thus obtained. One then determines which studies, *if any*, are indicated. And if studies are deemed necessary, the simpler ones are ordered first. In comparison, high-*tech* medicine essentially bypasses the medical history and physical examination, and, primarily on the basis of the patient's

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chief complaint, goes directly to a slew of tests that typically include magnetic resonance imaging or computed tomography, or both.

One other point is important. In bypassing or curtailing the history-taking and physical examination, the high-tech approach weakens the patient–doctor bond—or prevents it from ever forming. The high-touch approach, by contrast, represents the apotheosis of Oslerian medicine, ensuring that we treat the *patient*, not the disease.

The bottom line is this: While modern medical technology has greatly enhanced our ability to diagnose and treat disease, it has also promoted laziness—especially mental laziness—among many physicians. Habitual reliance on sophisticated medical gadgetry for diagnosis prevents physicians from using the most sophisticated, intricate machine they’ll ever and always have—the brain.

Is there a cure for this tyranny of technology? Any cure would be very difficult because, at a minimum, it would require a total revamping of our medical school teaching faculties. Currently, these faculties consist largely of two groups: fellows and young instructors who are fact-filled but experience-thin, and older professors who are proficient in only a narrow segment of their specialty. Both groups spend most of their time lecturing, writing papers, working in the clinics or laboratory, or traveling to meetings. These activities, whether school-decreed or self-imposed, limit contact between the faculty and trainees. And recent mandates limiting resident work hours further reduce such contact. What teaching there is takes place primarily in the lecture hall, conference room, or hallway outside the patient’s room, rather than at the patient’s bedside. Students and house officers end up spending more and more time attending lectures or conferences and less and less time attending their patients. With limited access to the teaching staff, the trainees turn to house officers and fellows one to two years their senior for instruction—a situation I consider “the blind leading the blind.”¹⁷

What do we need to alleviate and potentially reverse this trend? First and foremost, we need teachers who recognize that despite the specter of residency review committees, our job is to educate, not placate, our trainees.

Given that, we need more teachers who know and understand the pathophysiology, clinical features, and natural history of diseases; teachers who know what tests, if any, to order, when to order them, and how to interpret them; and teachers who use advanced technology to *verify* rather than to *formulate* their clinical impressions.

We need teachers who truly comprehend the value of a good medical history, the rewards of a pertinent physical examination, the power of knowing how to

think, and the importance of accountability; teachers who first use the stethoscope, not an echocardiogram, to detect valvular heart disease; teachers who first use the ophthalmoscope, not magnetic resonance imaging, to detect intracranial hypertension; teachers who first use their eyes, not a blood gas apparatus, to detect cyanosis; teachers who first use their hands, not computed tomography, to detect splenomegaly; and teachers who always use their brains and their hearts, not a horde of consultants, to manage their patients.

We need teachers who don’t order expensive, state-of-the-art studies when cheaper, conventional tests supply the same information; teachers who don’t administer a slew of medications in an effort to alleviate every possible ill; teachers who appreciate that doing nothing is, at times, doing a lot; and teachers who realize that many patients get well despite what we do, not because of what we do.

Unfortunately, these necessary role models are a vanishing species. Most of them have died or retired, and those who still have regular contact with medical students and house officers are too few to stem the tyrannical tide of those inured to the overuse of modern medical technology.

Can we possibly replenish these teaching role models? I don’t think so. But even if we could, it wouldn’t be enough. We need to take advantage of the role models who are currently practicing good medicine outside of academia. What these practitioners see and do each day bears scant resemblance to what students and house officers see and do in academia. Therefore, a good part of the clinical experience should take place in the real-world setting, supervised by experienced, compassionate, common-sense, real-world practitioners.

I fervently hope that current teachers of medicine can somehow recapture the Oslerian spirit and strive diligently to restore the very core of doctoring—humanism. Reaching that goal will require teachers with commitment, compassion, candor, and common sense. Teachers who understand and believe that medicine is a calling, not a business. Teachers who can look at, listen to, and talk with patients. Teachers who will work as hard and as long as it takes to ensure patients’ welfare. And teachers who always put patients first.

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